WORKSITE SCREENING
Request Form

Please complete this screening request form when you have determined the date, time, location and number of employees who wish to be screened at your worksite. Return the completed form to Prevention Partners 6 weeks before your proposed screening date.

Screening Coordinator Name:		
Worksite Name:		
Worksite Address:		
City:	State:	Zip:
Telephone:	FAX Number:	E-mail Address:
Location of Screening (Please include room name or number and attach directions if necessary):		
If this is a combined screening, please list the other participating worksites:		
Proposed Dates of Screening: 1st Choice _____ 2nd Choice _____ 3rd Choice _____		
Starting Time (Remember, there is a 12-hour fast associated with this screening):	Expected Number of Participants:	
Signature:	Date:	
Does your worksite have a Prevention Partners coordinator? ☐ No ☐ Yes — Name:		

Mail or FAX completed form to:

Prevention Partners
Employee Insurance Program
1201 Main Street, Suite 830
Columbia, SC 29201

Telephone: (803) 737-3820 **FAX: (803) 737-0793**

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South Carolina Budget and Control Board
Employee Insurance Program

The State Health Plan
PREVENTION PARTNERS